Testimony for the Program Review & Investigations Committee
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The American College of Emergency Physicians (ACEP) promotes the highest quality of emergency care and is the leading advocate for more than 28,000 US emergency physicians, their patients, and the public. The Connecticut Chapter (CCEP) represents close to 500 physician members living or working in the state of Connecticut.

The Emergency Departments (EDs) in the state of Connecticut continue to have increasing total patient volume, including an increase in visits from Medicaid patients. While the vast majority of ED visits are appropriate, at least prospectively from a patient's point of view, it is important to examine the areas for potential user reduction. Close examination of inappropriate use of the ED will likely suggest potential solutions that may allow for cost savings for the system, as well as better care for the patients. CCEP has identified the following issues as amenable to interventions to decrease ED utilization, which will ultimately reduce costs.

1. A major problem that Medicaid patients face is that few primary care physicians accept Medicaid patients due to reimbursement issues. Primary care physicians may choose to accept none, or just a small, limited percentage of their patient panel as Medicaid patients. For outpatient specialty care, there are even fewer options for Medicaid patients; often the only possibility is one of the two medical school affiliated clinics in the state, with months-long wait times for appointments. The Federally funded clinics (FQHCS) are often overcrowded, with limited hours, and may not be accessible to patients with transportation issues. So it is not uncommon to see a Medicaid patient in the ED for a problem that could have been managed by a primary care provider or specialist in the outpatient setting. These issues are not seen in the Medicare population; therefore it seems reasonable to assume that if Medicaid reimbursements reached parity with Medicare's, patients would have much more in the way of provider choices.
2. A major group of ED superusers are those Medicaid patients with alcohol and other substance abuse problems. Because of a deficiency of addiction treatment options, particularly rehabilitation programs and dual diagnosis programs, these patients are frequent ED users, some of them coming to the ED more than once a day. The lack of sober houses and the practice of bringing all patients who appear intoxicated to the ED has created a lot of extra ED use. It is proposed that sober houses, staffed with midlevel providers (Advanced Practice Registered Nurses and Physicians' Assistants), could safely staff sobering houses to markedly decrease the number of expensive ED visits for this group of Medicaid patients.
3. Another major group of ED superusers are those Medicaid patients with significant mental health challenges. These patients often stay in the ED for days, awaiting inpatient psychiatric hospital beds. This problem is particularly acute for

children and adolescents, as the state is woefully low on resources for this vulnerable patient population.

4. Many patients spend the majority of their lifetime health care dollars in the last three months of their life. End of life care is expensive when patients and families are offered and choose aggressive therapies that are not likely to change the outcomes. Palliative care is not only cheaper, but it is better care, and often can be provided in a home setting. Numerous outcome studies looking at quality of life and length of life have shown that patients enrolled in palliative care programs not only live longer, but also have higher quality of life ratings. However, Medicaid patients are much more likely to choose aggressive care rather than palliative care at end of life. There are also significant racial and ethnic differences in the rates at which patients and families choose palliative care programs. Providing education to patients and families about the benefits of palliative care programs could reduce ED health care utilization (and costs) that may not improve outcomes.
5. Finally, the state of Connecticut has serious issues with Medical Liability, which continue to drive up costs for everybody, including Medicaid patients. In the last ACEP state report card, Connecticut received a "D" and was one of the 15 worst states in the country. Lack of a Patient Compensation Fund, no limits on non-monetary damages, and one of the highest payout rates in the country have driven up malpractice premiums to the point where they are at almost double or more when compared to the national average. As a result of Connecticut's litigious environment health care providers find it necessary to practice defensive medicine. All of these costs are passed on to the consumer. Any ground lost on Medical Liability issues adds additional costs and decreases access for patients. In a state with one of the poorest Medical Liability rankings in the country, it is clear we cannot afford to sink any further.

I appreciate this opportunity to testify. I would be glad to answer any questions.